Quick Reference Guide for Clinicians

Treating Tobacco Use and Dependence

This Quick Reference Guide summarizes the guideline strategies for providing appropriate treatments for every patient. Effective treatments for tobacco dependence now exist, and every patient should receive at least minimal treatment everytime he or she visits a clinician. The first step in this process—identification and assessment of tobacco use status—separates patients into three treatment categories: Patients willing to quit, patients unwilling to quit, and patients who have recently quit.

Printed copies of Treating Tobacco Use and Dependence are available from any of the following Public Health Service clearinghouses: the Agency for Healthcare Research and Quality (800-358-9295); Centers for Disease Control and Prevention (800-CDC-1311); and the National Cancer Institute (800-4-CANCER).

Contents

To All Clinicians

The Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, on which this Quick Reference Guide for Clinicians is based was developed by a multidisciplinary, non-Federal panel of experts, in collaboration with a consortium of tobacco cessation representatives, consultants, and staff.

Panel members and guideline staff were:

Guideline Panel

Michael C. Fiore, MD, MPH (Panel Chair)
William C. Bailey, MD
Stuart J. Cohen, EdD

Sally Faith Dorfman, MD, MSHSA
Michael G. Goldstein, MD
Ellen R. Gritz, PhD
Richard B. Heyman, MD
Carlos Roberto Jaen, MD, PhD
Thomas E. Kottke, MD, MSPH
Harry A. Lando, PhD
Robert E. Mecklenburg, DDS, MPH
Patricia Dolan Mullen, DrPH
Louise M. Nett, RN, RRT
Lawrence Robinson, MD, MPH
Maxine L. Stitzer, PhD
Anthony C. Tommasello, MS
Louise Villejo, MPH, CHES
Mary Ellen Wewers, PhD, RN

Guideline Staff

Timothy Baker, PhD
Victor Hasselblad, PhD
Brion J. Fox, JD

An explicit, science-based methodology was employed along with expert clinical judgment to develop recommendations on treating tobacco use and dependence. Extensive literature searches were conducted and critical reviews and syntheses were used to evaluate empirical evidence and significant outcomes. Peer review was undertaken to evaluate the validity, reliability, and utility of the guideline in clinical practice.

This Quick Reference Guide for Clinicians presents summary points from the Clinical Practice Guideline. The guideline provides a description of the development process, thorough analysis and discussion of the available research, critical evaluation of the assumptions and knowledge of the field, more complete information for health care decisionmaking, and references. Decisions to adopt particular recommendations from either publication must be made by practitioners in light of available resources and circumstances presented by the individual patient.

As clinicians, you are in a frontline position to help your patients by asking two key questions: "Do you smoke?" and "Do you want to quit?" followed by use of the recommendations in this Quick Reference Guide for Clinicians.

Abstract

This Quick Reference Guide for Clinicians contains strategies and recommendations from the Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence*. The guideline was designed to assist clinicians; smoking cessation specialists; and health care administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions. It was based on an exhaustive systematic review and analysis of the extant scientific literature from 1975 to 1999, and uses the results of more than 50 meta-analyses.

This Quick Reference Guide summarizes the guideline strategies for providing appropriate treatments for every patient. Effective treatments for tobacco dependence now exist, and every patient should receive at least minimal treatment every time he or she visits a clinician. The first step in this process—identification and assessment of tobacco use status—separates patients into three treatment categories:

1. Patients who use tobacco and are willing to quit should be treated using the "5 A's" (Ask, Advise, Assess, Assist, and Arrange).
2. Patients who use tobacco but are unwilling to quit at this time should be treated with the "5 R's" motivational intervention (Relevance, Risks, Rewards, Roadblocks, and Repetition).
3. Patients who have recently quit using tobacco should be provided relapse prevention treatment.

Suggested Citation

Fiore MC, Bailey WC, Cohen SJ, et. al. *Treating Tobacco Use and Dependence*. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. October 2000.

Return to Contents

Purpose

Tobacco is the single greatest cause of disease and premature death in America today, and is responsible for more than 430,000 deaths each year. Nearly 25 percent of adult Americans currently smoke, and 3,000 children and adolescents become regular users of tobacco every day. The societal costs of tobacco-related death and disease approach $100 billion each year. However, more than 70 percent of all current smokers have expressed a desire to stop smoking; if they successfully quit, the result will be both immediate and long-term health improvements. Clinicians have a vital role to play in helping smokers quit.

The analyses in the Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, demonstrate that efficacious treatments for tobacco users exist and should become a part of standard caregiving. Research also shows that delivering such treatments is cost-effective. In summary, the treatment of tobacco use and dependence presents the best opportunity for clinicians to improve the lives of millions of Americans nationwide in a cost-effective manner.

Return to Contents

Key Findings

The guideline identified a number of key findings that clinicians should utilize:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.
2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
    - Patients *willing* to try to quit tobacco use should be provided with treatments that are identified as effective in the guideline.
    - Patients *unwilling* to try to quit tobacco use should be provided with a brief intervention that is designed to increase their motivation to quit.
3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user who is seen in a health care setting.
4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.
5. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).
6. Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients who are attempting tobacco cessation:
    - Provision of practical counseling (problemsolving/skills training).
    - Provision of social support as part of treatment (intra-treatment social support).
    - Help in securing social support outside of treatment (extra-treatment social support).
7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients who are attempting to quit smoking.
    - Five *first-line* pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
        - Bupropion SR.
        - Nicotine gum.
        - Nicotine inhaler.
        - Nicotine nasal spray.
        - Nicotine patch.
    - Two *second-line* pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:
        - Clonidine.
        - Nortriptyline.

- Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:
   - All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments that are identified as effective in this guideline.
   - Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

Return to Contents

Identification and Assessment of Tobacco Use

The single most important step in addressing tobacco use and dependence is screening for tobacco use. After the clinician has asked about tobacco use and has assessed the willingness to quit, he or she can then provide the appropriate intervention, either by assisting the patient in quitting (the "5A's") or by providing a motivational intervention, the ("5 R's"). Figure 1 (22 KB) can be used as a guide to identify both current and former tobacco users and to provide the appropriate treatment of all patients. The following three sections address the main three groups of patients:

1. Smokers who are willing to make a quit attempt.
2. Smokers who are unwilling to make a quit attempt at this time.
3. Former smokers.

Tobacco Users Willing To Quit

The "5 A's," *Ask*, *Advise*, *Assess*, *Assist*, and *Arrange*, are designed to be used with the smoker who is willing to quit.

Table 1. Ask—Systematically identify all tobacco users at every visit

Action	Strategies for Implementation
Implement an officewide system that ensures that, for every patient at every clinic visit, tobacco-use status is queried and documented.[a]	Expand the vital signs to include tobacco use or use an alternative universal identification system.[b]

Vital Signs
Blood Pressure:_____
Pulse: _____ Weight: _____
Temperature: _____
Respiratory Rate: _____
Tobacco Use: (circle one) Current Former Never

a Repeated assessment is not necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record.

b Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.

Select for Text Version.

Table 2. Advise—Strongly urge all tobacco users to quit

Action	Strategies for Implementation
In a clear, *strong*, and *personalized* manner, urge every tobacco user to quit.	Advice should be: • *Clear*—"I think it is important for you to quit smoking now and I can help you." "Cutting down while you are ill is not enough." • *Strong*—"As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you." • *Personalized*—Tie tobacco use to current health/ illness, and/or its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use on children and others in the household.

Select for Text Version.

Table 3. Assess—Determine willingness to make a quit attempt

Action	Strategies for Implementation

Ask every tobacco user if he or she is willing to make a quit attempt at this time (e.g., within the next 30 days).	Assess patient's willingness to quit: • If the patient is willing to make a quit attempt at this time, provide assistance. • If the patient will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention. • If the patient clearly states he or she is unwilling to make a quit attempt at this time, provide a motivational intervention. • If the patient is a member of a special population (e.g., adolescent, pregnant smoker, racial/ethnic minority), consider providing additional information.

Select for Text Version.

Table 4. Assist—Aid the patient in quitting

Action	Strategies for Implementation
Help the patient with a quit plan.	A patient's preparations for quitting: • *Set a quit date*—ideally, the quit date should be within 2 weeks. • *Tell* family, friends, and coworkers about quitting and request understanding and support. • *Anticipate* challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. • *Remove* tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car).

Provide practical counseling (problem solving/training).	• *Abstinence*—Total abstinence is essential. "Not even a single puff after the quit date." • *Past quit experience*—Review past quit attempts including identification of what helped during the quit attempt and what factors contributed to relapse. • *Anticipate triggers or challenges in upcoming attempt*—Discuss challenges/triggers and how patient will successfully overcome them. • *Alcohol*—Because alcohol can cause relapse, the patient should consider limiting/abstaining from alcohol while quitting. • *Other smokers in the household*—Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or not smoke in their presence.
Provide intra-treatment social support.	• Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. "My office staff and I are available to assist you."
Help patient obtain extra-treatment social support.	• Help patient develop social support for his or her quit attempt in his or her environments outside of treatment. "Ask your spouse/partner, friends, and coworkers to support you in your quit attempt."
Recommend the use of approved pharmacotherapy, except in special circumstances.	• Recommend the use of pharmacotherapies found to be effective. Explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.
Provide supplementary materials.	• *Sources*—Federal agencies, nonprofit agencies, or local/state health departments. • *Type*—Culturally/racially/educationally/age appropriate for the patient. • *Location*—Readily available at every clinician's workstation.

Select for Text Version.

Assist Component—Three Types of Counseling

Assisting patients in quitting smoking can be done as part of a brief treatment or as part of an intensive treatment program. Evidence from the guideline demonstrates that the more intense and longer lasting the intervention, the more likely the patient is to stay smoke-free; even an intervention lasting fewer than 3 minutes is effective.

The following three tables provide further detail and examples of the three forms of counseling that were found to be effective in treating tobacco use and dependence:

1. Practical counseling (problemsolving/skills training).
2. Intra-treatment social support.
3. Extra-treatment social support.

Table 5. Common elements of practical counseling

Practical counseling (problemsolving/skills training) treatment component	**Examples**
Recognize danger situations—Identify events, internal states, or activities that increase the risk of smoking or relapse.	• Negative affect. • Being around other smokers. • Drinking alcohol. • Experiencing urges. • Being under time pressure.
Develop coping skills—Identify and practice coping or problemsolving skills. Typically, these skills are intended to cope with danger situations.	• Learning to anticipate and avoid temptation. • Learning cognitive strategies that will reduce negative moods. • Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure. • Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention).

Provide basic information—Provide basic information about smoking and successful quitting.	• Any smoking (even a single puff) increases the likelihood of full relapse. • Withdrawal typically peaks within 1-3 weeks after quitting. • Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating. • The addictive nature of smoking.

Select for Text Version.

Table 6. Common elements of intra-treatment supportive

Supportive treatment component	**Examples**
Encourage the patient in the quit attempt.	• Note that effective tobacco dependence treatments are now available. • Note that one-half of all people who have ever smoked have now quit. • Communicate belief in patient's ability to quit.
Communicate caring and concern.	• Ask how patient feels about quitting. • Directly express concern and willingness to help. • Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
Encourage the patient to talk about the quitting process.	Ask about: • Reasons the patient wants to quit. • Concerns or worries about quitting. • Success the patient has achieved. • Difficulties encountered while quitting.

Select for Text Version.

Return to Contents
Proceed to Next Section